THE JOURNAL
of the
South Carolina Medical Association

VOLUME XXXVI September, 1940 NUMBER 9

Observations on the Conduct of Labor

J. DECHERD GUESS, B. S., M. D., GREENVILLE, S. C.

That master of epigram, the late Dr. Lane Mullaly, used to tell his students that the most important equipment to take with one on an obstetrical case was a pocketful of good cigars. While one musingly enjoys a cigar, he is not likely to be tempted to interfere with the normal course of labor, and nature is allowed to work without needless molestation. Wise is he who leaves to nature the accomplishment of delivery, unless he is sure that by interference he can add to the safety of either the mother or the child.

The mechanism of labor is of necessity slow moving, and attempts to hasten it are fraught with dangers. However, non-interference in labor does not preclude a thorough knowledge of its mechanism, and such knowledge is requisite to peace of mind. It is necessary, if one is to recognize events which might make intervention advisable and it is obligatory before intervention can be wisely purposeful.

Rare, indeed, is the obstetrical emergency which can be met best by hasty delivery by any method. Glance at the list: Onset of eclampsia, uterine hemorrhage, maternal exhaustion, failure of the fetal heart, prolapse of the cord, non-engagement of the presenting part, prolonged perineal stage, development of retraction ring, atony of the uterine muscle. None of these with the rare exceptions of prolapse of the cord and failure of the fetal heart demand rapid delivery for their solution, and in each of them, potential dangers are increased greatly by such a course. The fact that so-called obstetrical emergencies are made worse by hasty delivery of the child has been clearly indicated by the experience of that growing group of hospitals which requires consultation before the attendant proceeds with delivery in such cases. The fact that consultation is required, necessitating the lapse of a variable amount of time after the recognition of the emergency before active interference can be instituted, has dramatically reduced both maternal and fetal mortality and morbidity.

Preparation for the scientific conduct and the honest supervision of labor necessitates a medical familiarity with that particular patient, a knowledge of the expected mechanism of labor, adequate armamentarium, and skillful and frequent observations throughout her labor. Nothing less will constitute adequate care, and although one may bungle through many times with success and satisfaction without such care, preventable catastrophes will occur occasionally — catastrophes which are shocking but which may be soon forgotten, perhaps, fortunately for the sanity of the doctor.

Complete knowledge of the patient can be gotten only by study from time to time throughout pregnancy. With obstetrical practice as it is, such ideal study is often impossible, although great improvement in this regard has been made in South Carolina in the past half decade. However, even though the doctor sees

Read before the South Carolina Medical Association, Charleston, S. C., May 1, 1940.

his patient for the first time after labor has begun, he can familiarize himself with the peculiarities of the case to a considerable degree by short, systematic examination. While doing this, he will be building up in the patient a confidence which will be helpful in case difficulties arise.

The doctor should seek answers to these questions: Is the hemoglobin adequate? What is the blood pressure? Is there significant albuminuria? What is the presentation and the position of the baby? Is there cephalo-pelvic disproportion? Is the pregnancy multiple? Is the pelvic passage obstructed by tumors, prominent ischial spines or rigid os coccyx? What is the shape, consistency and position of the cervix? Valuable information with regard to these questions may be gotten without great expenditure of time and using little equipment. Study of the pelvic canal may be made through the rectum. Vaginal examinations can not be done wisely before ruling out indications for cesarean section. Even then, such examinations should not be done without careful preparation of the vulva and of the examiner's hands.

Only slightly less important than a thorough knowledge of the patient in the safe and convenient conduct of labor is the possession of a carefully planned and adequate armamentarium. It should not be understood that the carrying of equipment sufficient to set up a hospital delivery room is being suggested. Such a load of equipment would entail too great expense, and needlessly so, for the average South Carolina doctor. For had he such an outlay, much of it would be useless without trained assistants. Some equipment is almost obligatory. One should have rubber gloves and a soft rubber catheter, some preparation of ergot, pituitary extract, ether or chloroform and a mask to administer them. He should also have scissors, needles, needle carriers, suture material, several hemostats, and a pair of obstetrical forceps. The latter are the least important item in the list. The instruments should be sterile, or should be rendered sterile by boiling after reaching the case. Soap and water thoroughly applied is the best cleansing agent for the vulva, perineum and adjacent surfaces, and variously colored antiseptics are not required. A small amount of sterile linen is a safeguard and a convenience. Ordinarily clean linen, dry or soaked in lysol solution may be substituted for sterile linen, if its deficiencies are recognized, and such linen is safer when so used than is the careless use of once sterile linen which has become grossly contaminated. It is possible to do a safe delivery with no linen.

Severe anemia greatly increases the hazards of labor and delivery. Its mere presence should constitute an emergency sufficient to warrant hospitalization. Blood transfusion, safe intravenous infusions and careful asepsis should be available to such women.

The conduct of the first stage of labor is essentially inactive. The dangers of this stage are not numerous and are not usually severe. The most serious complication is rupture of the uterus but this is quite rare. When it occurs, it is usually the result of the administration of pituitary extract. Rupture of the uterus requires prompt hospitalization and laparotomy. The mortality is high even when recognized promptly and wisely treated. A more frequent complication of this stage is hemorrhage, either from placenta previa or apoplexy of the placenta. Placenta previa centralis is serious and is best treated by cesarean section. Fortunately warning hemorrhage, usually not fatal, usually occurs before the onset of labor. Lateral placenta previa is hardly so serious and can frequently be safely managed at home by rupture of the membranes or by Braxton-Hicks version. Attempt at rapid delivery in placenta previa is a mistake of greatest magnitude. Abruptio placenta is frequently not recognized. Spontaneous delivery without serious blood loss may occur. When placental separation is extensive and is accompanied by severe hemorrhage and shock, the mortality is high. The best treatment is cesarean section, using local infiltration anesthesia, preceded and followed by blood transfusion. Transportation to hospital is warranted, if this accident occurs at home.

Failure of complete cervical dilatation is a complication of the first stage of labor which is more frequently diagnosed than it occurs. The time element enters here. The time required for the complete dilatation of the cervix varies

and no deadline should be set for its termination. It is quite possible for the first stage of labor to continue through one or more days, but active labor will have been intermittent rather than continuous. In cases of occiput posterior, in breech cases, and in premature labor, where the cervix is still long and firm, prolongation of the first stage of labor may be expected and its mere length should cause no great concern. In such cases the nutrition and the fluid level of the patient should be maintained by the giving of fruit juices and other liquids. Her strength should be conserved by adequate rest, induced preferably with an opium derivative. It is important that the doctor keep the situation in hand and that he control his own and the impatience of the family. Needless vaginal examinations should not be made, and no effort at manual dilatation of the cervix should be attempted. Rarely, the cervix will ultimately fail to dilate, and when this is the case, hospitalization should be considered. Cesarean section may be the preferable method of treatment if the vagina has not been carelessly invaded, and Duhrssen's incisions of the cervix are preferable to manual avulsion.

Rupture of the membranes before the onset of or early in labor was formerly dreaded because of the resultant dry labor. Instrumental rupture of the membranes has lately come to be an acceptable and valuable method of induction of labor. After such rupture of the membranes labor is likely to be unusually short in the case of the more favorable occiput anterior positions. It is not the dryness which makes dry labors long and hard, but the unfavorable presentation or position, which has favored the premature rupture of the membranes.

Many women neither demand nor need analgesia in the first stage of labor. But many other women do demand it, and some seriously need it. Morphine or another opium derivative is especially useful in the early stages. One of the barbiturates, and I prefer sodium pentabarbiturate, or nembutal, is relatively without danger, and is satisfactory in most cases, but it should be given in larger doses than those frequently used. Rectal administration of ether, ether and paraldehyde, or ether and barbituric salt is successfully used by many, but this method is not well adapted to home deliveries.

Auscultation of the fetal heart tones during the first stage of labor has little practical value and might as well be dispensed with in most cases delivered at home.

Allowing or encouraging the woman to bear down with her pains before the cervix is fully dilated or is easily dilatable is a most pernicious practice permitted and even requested by many doctors, demanded by most graduate nurses, and urged upon her by practically all relatives and friends.

That part of the second stage of labor before the perineal period should be handled in a manner similar to that of the first stage. But in the second stage, and differing from the first, the expulsive forces subject the fetus to potential trauma, and the time element is more important. Further, the baby is now subject to instrumental extraction in case of fetal distress or failure of descent. For this reason, the fetal heart tones should be carefully checked from time to time and rotation and descent followed. Particularly is the latter true in occiput posterior positions. Undue prolongation of failure to rotate anteriorly, notwithstanding good contractions, and a similar prolongation of the perineal stage invite interference in the interest of both mother and baby. Manual or instrumental rotation, provided one knows and exercises all the safeguards and uses a safe technique, saves mothers and babies from unnecessary injury. However, unless one knows the cause of the difficulty, employs the safeguards and exercises skillful technique, it is better to remain inactive and to lessen rather than to increase the analgesia, and to leave it to the natural forces to overcome the dystocia. The operation of episiotomy is so simple, that it should be used whenever the expulsion of the child is too long retarded by an unyielding perineum.

Chloroform judiciously administered intermittently is almost if not quite as satisfactory during the perineal stage of labor as is nitrous oxide gas. Ether is less satisfactory for intermittent administration, but is safer for continuous or deep anesthesia.

Papers much longer than this discussion have been written on the management of the third stage of labor, but here only a few terse remarks will be made concerning it. The inventor of Crede's original method of expulsion of the placenta discarded that method because he encountered serious hemorrhage too frequently when using it routinely. This method rarely has a place in modern obstetrical practice. Simple manual expression of the already separated placenta, whether by the so-called modified Crede technique or by one of several other manouvers which have been described is a valuable and time saving procedure, and one that is strongly advisable if the practice of administering pituitary extract early in the third stage is adhered to. Usually inability to express the placenta after a reasonable length of time is due to incarceration of the already detached placenta by hourglass contraction of the uterus or to the inability of a large placenta to pass through an already partially contracted cervix. Less frequently it is caused by failure of placental separation due to tonic contraction of the uterus, this in turn having been caused by ill-advised massage or by too early efforts to express the placenta. Manual removal of the placenta is indicated at the end of an hour if expulsion has not been brought about. Again all of the safe guards should be exercised, for this is a procedure fraught with danger of infection. If no plane of cleavage between placenta and uterine wall can be found, diagnose the condition as placenta accreta, a very rare occurrence, indeed. In such a case do not attempt to forcibly tear the placenta away. Hospitalize the patient and do a hysterectomy.

Finally, many serious postpartum hemorrhages may be prevented by administering an adequate dose of a potent preparation of ergot at the end of labor. It is well to leave a dose or two with the patient, so that it may be taken later if bleeding becomes too free. A potent ergot preparation is almost synonymous with one of the preparations of ergonovine. Many heartaches will be prevented by careful inspection of the placenta and by investigation of the uterine cavity in case it and the secundines do not appear to be intact.

The Orthopaedic Problem in the South

AUSTIN T. MOORE, M. D., COLUMBIA, S. C.

When I was approached with reference to preparing a paper for this meeting, the subject assigned was "The Control of Congenital Deformities." Obviously there is little possibility of solving that problem in a satisfactory way. The subject was changed to "The Orthopaedic Problem in the South." This topic is almost equally as difficult to approach; but I will attempt to outline what the problem is; what it is not; and what can be done about it.

HISTORICAL INTRODUCTION

The word orthopaedic, as you perhaps already know, is derived from the Greek orthos—to straighten, and pedia—a child. The term orthopaedic surgery, therefore, was originally used to describe that branch of surgery limited to the practice of straightening the crooked child; in other words, the science and art of healing crippled children. The practice of orthopaedic surgery began very early and is almost as antique as is our knowledge of the human race. Hundreds of skeletons have been unearthed from ancient burial grounds in Europe, Asia and Northern Africa which show a variety of bone injury and pathology. For example, there is seen in the original Neanderthal skeleton a fracture of the ulna which has healed in good position. There was, of course, no attempt at bone surgery as we know it today. Where there was an acute bone infection present, the disease either ran a self limited course or ended fatally. Paleolithic man probably acted as other high grade animals and treated his fractures instinctively. By judicious rest with possibly some form of support, fol-

Read before the Conference on Tomorrow's Children, Atlanta, Georgia, November 11, 1939.

lowed by cautious return of motion, no doubt some excellent results were accomplished. At some time during the course of Neolithic development knives and saws were invented and the first evidence of amputated stumps was found. In the caves of La Tene in France many illustrations of crippling conditions have been discovered. Perhaps the earliest of all bone operations was the practice of trepination. Sharpened stones were used to make the opening in the skull, and in spite of absolute ignorance of asepsis, many of the patients recovered. Trephined skulls have not only been found in old world deposits, but also in the burial grounds of pre-Columbian America. Most of these operations were performed at the insistance of the early European witch doctor, or the American Indian medicine man. Preliminary incantations of a weird nature, prayerful concoctions and noisome ceremonies having already failed to drive out the evil spirits. However, Hrdlicka, the eminent anthropologist of the Smithsonian Institute, has recently demonstrated that in many instances trepination may have been done in cases of head injury with fracture of the skull to relieve the development of paralysis and coma. It is known that the natives of India were taught to believe that they could obtain health and happiness by drinking the dirty and polluted water of the Ganges river, and it is further known that the virtue of society during the incumbency of the Pharoahs called for extermination and destruction of all children born with crippling deformities; however, at that time and long years before then a great deal was done in a scientific way to care for the sick and crippled. Archeologists working in a Nubian Desert have uncovered mummies dating back to the Fifth Dynasty (2750-2626 B. C.). Some of these bodies had fractured limbs still bound in splints which were evidently ingenious and effective. As early as 1000 years B. C., the Greco-Roman temples became centers of medical service and the spa, which is one of the oldest of all therapeutic institutions, thrived on the treatment of arthritis and various other orthopaedic conditions. The great establishments at Cos and Epidauros cared for the crippled, deformed and disabled and became the patterns after which Christianity in later centuries modeled its hospitals.

That most remarkable of all physicians, and the man who is considered as the father of medicine, Hippocrates, lived about 400 years B. C. He wrote a truly astounding series of volumes which were the earliest scientific treatise on medicine and which have been named after him the Corpus Hippocrates. Many of the basic principles underlying the practice of orthopedic surgery can be found in his books and although it was the custom among early Greeks to destroy infants with congenital deformities and defects, he described spinal curvature, club foot and congenital dislocation of the hip. He recommended physical therapy, bracing and bandaging and had recourse to splints, artificial limbs, braces and club foot corrective shoes.

While a slight sentimental interest may have existed among early people, the social consciousness toward crippled children was not aroused until Jesus of Nazareth gave first impetus to it during His brief ministry here on earth. He taught the propriety of healing the sick, the maimed, the halt and the blind. He said "Suffer the little children to come unto Me and forbid them not for of such is the Kingdom of Heaven."

The idea of being "my brother's keeper" did not continue after the time of Christ insofar as State responsibility or the responsibility of society as a whole is concerned. As late as the Renaissance even so great a teacher as Martin Luther suggested that the rachitic baby be tossed into the river and drowned. As Christianity progressively spread its teachings throughout the world, there was a progressively increasing interest in ones more unfortunate fellow man. The first public act which specifically provided aid for the crippled was passed in England about 1600 A. D. during the reign of Queen Elizabeth. An interesting evidence of English tolerance was shown in the fact that many of the court jesters were cripples—especially hunchbacks.

The development of orthopaedic surgery progressed through the years, but it may be truly said without disparagement that until approximately the beginning of the present century orthopaedic surgeons were a more or

less dignified group of harness makers, manipulators and splint builders. There were comparatively few cutting operations. The New York Hospital for the Ruptured and Crippled, established in 1863, was the first institution of its kind in America. Philadelphia followed with a similar institution in 1884. Orthopaedic surgery received its greatest impetus after knowledge of asepsis and X-rays had been introduced and during the recent World War when it was learned that extensive bone reconstruction and grafting operations could safely be accomplished. About this time orthopaedic clinics began to develop in smaller medical centers throughout the country. Large appropriations and endowments were made by States, fraternal organizations and by wealthy private citizens for the erection and perpetuation of institutions for the care of crippled children. The Shrine hospitals throughout this country are perhaps the most widely known group of institutions, and the Warm Springs Foundation in Georgia is perhaps the most widely recognized single institution. During the past five years the "President's Balls" have brought knowledge of this hospital to every village, town and hamlet in America.

Orthopaedic surgery has developed from a very humble beginning until now it is rightfully recognized as one of the leading specialties in medicine. It has found its proper place in the medical curriculum and special courses are being taught. Volumes of research work have been published. Special instruments and equipment have been perfected, various teaching institutions have been created. Moving pictures and other modern methods are used freely for teaching purposes and demonstrations to physicians, nurses, social workers and others of the personnel interested in orthopaedic problems. Within the past few years especial societies have been organized and examining boards created to determine the eligibility and fitness of those who wish to take part in the practice of this specialty.

It was not until August 14, 1935 that the United States Government took cognizance of the responsibility to the unfortunate cripples of this country. On this date, under the Social Security Act, title V, Part 2, funds were authorized for service for crippled children in all of the States, Alaska, Hawaii and the District of Columbia. It was not until February 1, 1936 that these funds became available. Administration of these funds was entrusted to the Childrens Bureau of the Department of Labor and a childrens division was established under the direction of a physician directly responsible to the Assistant Chief of the Bureau, who is also a physician. As late as that year, 1936, there were still twelve states failing to provide directly for care of crippled children. Most of these states were located in the South. Because the Federal grant is a matched dollar for dollar program, advantage was soon taken of the appropriation and today, just three years later, every State in the Union, the two territories and the District of Columbia have designated agencies to provide services to crippled children. Approximately twenty million dollars a year is being spent to relieve and rehabilitate these unfortunates.

Due to diminished wealth in the South as compared with the North, there have been less adequate orthopaedic facilities and consequently remedial services have been available to fewer cases. However, it has been determined that special institutions are not always necessary or even at times desirable for the care of crippled children. In many sections of the South these patientts have been hospitalized in general hospitals and the fact that a cripple realizes that he is getting well side by side with an otherwise normal individual frequently is a great stimulant psychologically.

ORTHOPAEDIC PROBLEMS

The causes of crippling in children can be classified under four general headings.

1. Development deficiencies.
2. Congenital anomalies
3. Infections, acute or chronic
4. Trauma (injury)

1. *DEVELOPMENT DEFICIENCIES*: Rickets perhaps heads the list of conditions due to malnutrition. Bow legs is the most common deformity, and is due to bearing weight on bones softened by an inadequate deposit of calcium. Fortunately in the South we have an abundance of sunshine the year round. This factor, acting synergistically with

vitamin D found principally in cod liver oil, usually effects a cure. There are other nutritional diseases such as scurvy and beriberi. Also there are numerous dystrophies and developmental deformities due to osteochondritis and other untoward influences on growth centers of the bone. Scoliosis (curvature of the spine), round shoulders and flat feet are examples of growth deficiciencies and postural defects.

II. *CONGENITAL ANOMALIES.* Club feet are seen in the South more commonly than any other type of congenital deformity. There are numerous other conditions, for example: harelip, cleft-palate, wry-neck, congenital dislocation of the hip, webbed fingers and supernumerary or abnormally deficient members. The earlier treatment can be begun the better will be the end result.

III. *INFECTIONS, ACUTE OR CHRONIC.* No condition coming under the discussion of problems met in treating crippled children presents more varied deformities and more perplexing difficulties than poliomyelitis or infantile paralysis. The disease affects the central nervous system whereby the muscles are deprived of their power to act and as a result there is wasting away of the extremities with contractures and varying deformities. Poliomyelitis should be treated at once by orthopaedic appliances and if the patient is seen early the development of deformities is inexcusable. Many cases make complete recoveries from what in the beginning appears to be extensive paralyzing conditions. In cases where muscle power does not return many brilliant results can be accomplished by appropriate surgery to transplant muscles and stabilize joints by fusion.

Other diseases causing crippling conditions are osteomyelitis, tuberculosis, arthritis, syphilis, meningitis and new growths of a benign or malignant character.

IV. *TRAUMA (INJURY).* Birth injuries are responsible for a large number of patients seen in orthopaedic clinics in the South. Due to failure to secure adequate obstetrical services, and the common practice of midwifery many of these conditions are brought about. Spastic paralysis from injury to the brain during delivery is frequently seen. Frequently the mental condition is so poor that even though relief of the crippling condition is possible the child still would not have sufficient mental acumen to use its own extremities for locomotion and useful purposes. These conditions are the most hopeless and pathetic encountered in orthopaedic practice. Spastic paralysis is not always due to injury and may be caused by disease or deficiency in the germ cell plasm. Other birth injuries may be fractures of the bones, or damage to the peripheral nerves or spinal cord. Obstetrical paralysis is frequently seen as a paralysis of the arm due to stretching of the infant's neck or shoulder at the time of delivery. Careful obstetrics frequently prevent these conditions.

Injuries to normal individuals make up a large part of the practice of many orthopaedic surgeons. More accidents occur in the home than in any other location. Next in order of frequency are injuries found in public places, occupational accidents and finally motor vehicles. Although motor vehicles are responsible for fewer accidents, they lead in the number of fatalities. Every year in America there are at least 500,000 broken arms, legs or backs and of that number fully 25,000 are permanently and totally disabled.

PESENT ORTHOPAEDIC FACILITIES

In addition to the problem of caring directly for the physical disability of a child, there is the problem of institutional care, social service and field work, dissemination of knowledge concerning orthopaedic facilities, physical therapy, occupational therapy and rehabilitation, and the preservation and promulgation of a child's education while he is out of school during treatment.

The South has more recently become better supplied with orthopaedic clinics, several of which are of the finest character and enjoy international reputation. There are a number of State and privately controlled institutions, splendidly equipped and operating solely for the care of crippled children. Due to natural climatic advantages, clinical and convalescent home treatment can be carried out uninterrupted throughout the entire year. Good roads

recently developed help to a great extent in making this possible. Several of the Southern States now boast of having as fine a system of paved roads as any in the Union. Sunshine, which is available the year round, is of great benefit in the treatment of many orthopaedic ailments and the fresh vegetables and fruits that are found in the South are of particular advantage in preventing and relieving nutritional deficiencies.

An effort has been made to study the orthopaedic conditions found in the South. Over 50,000 cases from widely scattered localities were reviewed. Due to the fact that there is no universally accepted definition for either a crippled child or an orthopaedic condition, it was soon found that an accurate comparison of statistics is impossible. For example; some clinics admitted children up to 21 years of age, others limited their cases to 12 or 14 years. Some clinics included harelip, cleft-palate, sight or hearing deficiencies and cardiac aliments as crippling conditions. Cerebral palsies with and without mental impairment have been excluded from certain clinics. Traumatic conditions and osteomyelitis have in certain localities been treated mainly by the general surgeon. These and many other factors make an accurate statistical comparison impossible. An attempt has been made to draw a few general conclusions. Arthritis is not as prevalent as it is in harsher climates. Osteomyelitis is seen frequently, and there is a high proportion of club feet to other congenital deformities. Congenital dislocation of the hip is not as commonly found as in other sections. It is an interesting fact that certain congenital deformities occur more frequently in certain geographical areas. For example, in Southern Italy more than in any other part of the world there occur many cases of congenitally dislocated hips. This condition is relatively rare in the South. Tuberculosis of bone is not so common in the South. Statistics accumulated over a period of years and covering a great number of cases show that throughout the nation the number of congenital deformities comprise from one-fourth to one-half of all orthopaedic cases seen. This does not seem to be true in the South as the average is approximately twenty percent of the total cases. In other words, these figures indicate a fact about which we should be justly proud. The chances of having a normal healthy baby without deformity are better in the South than in any other section of the country.

CONSIDERATIONS FOR THE FUTURE

The South needs increased funds with which to carry out more adequate orthopaedic programs. However, it is probably true that for every dollar spent the patient in the South receives more direct benefit than elsewhere. Wherever there are elaborate establishments so much of the money must be used for overhead and personnel expenses.

The Southern States agree that efficiency and economy in the care of crippled children demands a great deal more than simply the care of an orthopaedic surgeon. Proper maternal hygiene and pre-natal care are essential. Orthopaedic cases must be found early and reported to clinics. Social service workers must assist the child and his family, and when necessary make the proper social and psychological adjustment that crippling may require. Home visits during the convalescence for dressings, physical therapy, or for observation and report are especially helpful. Academic education should go on uninterrupted and vocational rehabilitation should be available when indicated. One of the greatest needs is for the dissemination of knowledge to certain communities that orthopaedic service is available and can be relied on to bring about improvement. The State Boards of Health have been especially cooperative in all of these particulars and the establishment of convalescent and boarding homes has greatly broadened the program.

The International Society for Crippled Children, at its tenth annual convention, declared the crippled child's "Bill of Rights." In abstract it follows:

1. Every child has a right to be well born of healthy parents.

2. Every child has a right to develop under clean, healthy and wholesome conditions.

3. Every crippled child has the right to have the earliest possible examination, diagnosis and treatment.

4. Every crippled child has the further right

to have proper post-operative care and all necessary appliances.

5. Every crippled child has the right to an education.

6. Every crippled child has the right to such training as will fit him or her for self support.

7. Every crippled child has the right to vocational placement.

8. Every crippled child has the right to considerate, sympathetic and understanding treatment.

9. Every crippled child has the right to spiritual as well as bodily development.

10. In brief, not only for its own sake, but for the benefit of society as a whole; every crippled child has the right to the best body which modern science can help it to secure; the best mind which modern education can provide; the best training which modern vocational guidance can give; the best position in life which its physical condition, perfected as best it may be, will permit; and the best opportunity for spiritual development which its environment affords.

The final goal towards which we should strive might be stated in the words of that greatest of all orthopaedic sugeons — Sir Robert Jones—"It can never be realized too widely that deformity is an unnatural and preventable affliction which treatment may alleviate or cure, but which a more complete understanding could abolish."

Regional Enteritis

A. F. BURNSIDE, M. D., COLUMBIA, S. C.

The term Regional Enteritis is chosen from a number of titles designating a clinical entity which may manifest itself as an acute, sub-acute, or chronic inflammatory process in the small intestine; sometimes resulting in cicatrization, stenosis, fistula or abscess formation. Many of these cases are not diagnosed pre-operatively, especially the acute cases due to their similarity to acute appendicitis or acute Meckel's diverticulitis. In the sub-acute and chronic cases, intestional Tuberculosis, Ulcerative Colitis, Hodgkin's and Neoplastic Disease may closely simulate Regional Enteritis.

In 1932 Crohn, Ginzberg, and Oppenheimer brought to the attention of the profession, terminal ileitis. Prior to this time there had been sporadic mention of no specific small bowel infective granuloma. W. J. Mayo wrote an article on this subject in the nineties. But no one had specifically classified this disease before Crohn, Ginzberg, and Oppenheimer and there has been little added to their first description except that the condition may affect any segment of the small intestine and rarely the colon.

ETIOLOGY: The cause is unknown. It occurs most often in the young adult. Some of the proposed causes are: (1) primary infection of the appendix spreading to the ilium, (2) bacillary dysentery, (3) relationship to lymphogranuloma inguinale, (4) a superficial likeness between mesenteric lymphadenitis and regional enteritis has caused some to suppose that it may be due to a low-grade infection of the lymphatic system. Cultures from the lesion are usually sterile or mixed. An anerobic streptococcus has been obtained from the peritoneal fluid and from the lymph glands in the mesentery, but when this culture was injected into animals the lesion could not be reproduced. The tubercle bacillus has not been demonstrated. Luetic tests are usually negative. The disease is possibly more common in the Hebrew but no statistics are available.

PATHOLOGY: The pathological process can be divided for clinical purposes into three stages: (1) acute regional enteritis, (2) chronic hypertrophic enteritis with ulceration and stenosis, and (3) chronic ulcerative enteritis associated with external or internal intestinal fistula.

In acute regional enteritis there may be considerable light straw-colored fluid with high viscosity containing numerous leucocytes and

Read before the South Carolina Medical Association, Charleston, S. C., May 2, 1940.

no bacteria or culture with ordinary media. It most frequently involves the terminal ilium but may involve any portion of the small bowel. In one of my cases, the lower jejunum was involved for about ten inches. The bowel wall was several times normal thickness. The mesentery was thickened and contained many enlarged lymph glands. The serosa of the bowel was discharging a sticky serous fluid. Portions of the serosa most distal to the mesentery were blood red, involving areas half the circumference of the bowel. No ulcerations of the mucosa were palpable. There were several other areas of bowel involvement which showed a simple oedema and slight congestion.

No histological studies have been made of the bowel in the acute cases as everyone seems to agree that resection is contra-indicated at this time. But as the disease progresses the bowel changes are characteristic. The bowel becomes more thickened and edematous, less injected, and the serosa is granular, somewhat like tuberculosis, though the nodules do not tend to bleed as easily. The mesentery is thickened and contains numerous markedly enlarged lymph glands. The affected loop of bowel tends to adhere to other structures. On opening the resected portions the walls are extremely thickened and the lumen is encroached upon. The lesion seems to begin in the mucosa along the mesenteric attachment as the ulcers predominate in this area. The disease shades off into normal bowel and there may be several inches to several feet of normal gut, then another segment of involvement.

In the most advanced cases the intestine is somewhat like a soggy rubber hose. The mucosa has a cobble stone appearance, due to the healing and contracture of the ulcerations. There is stenosis and the intestine proximal to the lesion is dilated. There is a marked tendency to sinus and fistula formation with occasional abscess. Acute perforation is rare, due to the early formation of adhesions to other structures. Internal fistulae are common to the caecum, sigmoid, transverse colon or segments of small intestine.

There are no specific microscopic findings that will differentiate it from other chronic inflammatory lesions. The lymphoid cell seems to predominate except in the acute cases. The small lymphocyte, plasma cells, and fibroblastic elements are prominent. Eosinophiles are frequently present. Giant cells found here and there and associated with patches of lymphocytes under the serosa gives a picture somewhat like tuberculosis, no organism which might be considered the cause of this pathological process has been demonstrated.

CLINICALLY, regional enteritis prefers the young adult two to one, but young children and the elderly individual are not exempt. The disease is more common in the male. The symptoms correspond to the stage of the disease; the most prominent being: abdominal pain, cramps, nausea, vomiting, slight distention, mild anemia, loss of weight and strength. The first stage of the disease is that of an acute inflammation, with pain over the lower abdomen (frequently right lower quadrant), fever, nausea, vomiting, and leucocytosis. In this stage it is almost impossible to differentiate it from acute appendicitis. The second stage is that of partial obstruction. Excessive peristalsis, with cramps, diarrhea, nausea, vomiting, and a low-grade fever, all of which may be intermittent. A mass may be palpated in the right lower quadrant. As the disease progresses the stenosing symptoms become more prominent, such as distention, severe cramps, malnutrition and anemia. The third stage is that of obstruction, perforation with abscess or fistula formation, with intractable vomiting and marked distention, or marked anemia and extreme malnutrition. Remissions are common in the first and second stages. The stools contain mucus and are frequently positive to benzidine, but seldom contain gross blood.

The diagnosis may be confirmed by X-ray in the more advanced cases. Barium is given first by enema since it is possible to convert a partial obstruction into a complete one by the packing effect of the barium. When possible the barium should be given both by rectum and by mouth. The X-ray findings of note are: (1) a "string sign" representing the actual lesion, (2) dilatation of loops of small intestine just proximal to the lesion, (3) a filling defect in the small intestine, (4) fistulous communications between the small intestine and colon may lead to delayed motility and

cause a mild constriction at the sight of the fistula. Careful roentgen examination with a barium enema may disclose a fistula between the small intestine and colon. The injection of iodized oil into an external fistula which results from a regional enteritis should show the connection between the fistula and small bowel. Chronic ulcerative colitis is the most common disease that has to be differentiated from chronic regional enteritis. Other lesions that must be thought of are actinomycosis, malignancy, appendiceal abscess, tuberculosis, syphilis and foreign body.

The difficulty in treatment of the acute cases lies first in making the diagnosis, this is seldom made until the abdomen is opened. If the disease is in the terminal ilium the abdomen should be closed without attempting anything further. If the lesion is high up on the small bowel I see no objection to removing the appendix, but if the disease involves the terminal ilium and the appendix is removed a permanent fecal fistula may follow. I know a doctor's daughter in whom this occurred. Several attempts were made to close the fistula, but finally, she had to have her terminal ilium and caecum resected and an iliocolostomy performed. Most authors agree that resection should not be done in the acute stage because a percentage will get well without it. I believe that complete rest of the entire gastro-intestinal tract for eight to ten days, giving the patient fluids intravenously and transfusions if necessary during this interval then instituting a bland diet and medication, such as is given in ulcerative colitis, will cure a large percentage of the cases. If symptoms persist or recur the risk of resection can be evaluated and the necessary time taken to build up the resistance and to properly prepare the patient for such a major operation.

The choice between medical or surgical treatment of the chronic stenotic case depends on the degree of stenosis and the resulting symptoms. In many instances resection will offer the best chance of a permanent cure. The choice of a one or two stage operation should be considered in each case. If the patient is a poor risk, a two stage procedure should be done, first short-circuiting the ilium to the transverse colon and closing the distal end of the ilium. A point eighteen to twenty-four inches on the intestine proximal to the disease should be selected for the anastomosis and the small bowel should be searched to determine if there are multiple lesions because several feet of normal bowel may intervene, so called skip areas. The leaving of diseased bowel is one explanation for recurrences. If the patient is in good condition a resection of the involved small intestine can be done with an Entero-enterostomy or Entero-colostomy. In the advanced cases with fistula of abscess formation the two stage procedure seems to be the one of choice.

Regional Enteritis complicated by external fistulae can usually be cured only by resection of the diseased intestine and excision of the sinus tract. Any patient that has had an appendectomy with post-operative fecal fistula which does not heal spontaneously in a few months probably has an unrecognized regional enteritis.

SUMMARY

A review of regional enteritis is attempted with the following conclusions drawn from personal experience and literature published to date that, (1) a specific etiology has not been determined, (2) the acute stage is hard to diagnose preoperatively, (3) that mild chronic forms exist for years with few symptoms and are difficult to diagnose with present methods, (4) there are well defined cases that bowel resection and Entero-enterostomy or Entero-colostomy are indicated, (5) that the primary acute case should be treated by complete gastro-intestinal rest for a period, (6) that there is no known drug that has any specific curative effect, (7) that the disease is not a specific pathological but is a definite clinical entity.

DISCUSSION

DR. F. E. KREDEL (Charleston): Dr. Burnside gave a very excellent paper. I have learned a good deal from his paper because we happened to have a case of acute terminal ileitis in the hospital upon which we did an appendectomy twelve days ago. I am surprised to hear that fecal fistula develops after appendectomy because this disease usually stops at the ileocaecal valve and does not involve the caecal wall. In the future I will be more careful about taking out appendices in such cases.

I was interested to know that acute cases not

very often get well. Our man is on the 12th day of postoperative care. We kept him off food eight days and he is now on soft diet. He is one of the few men on the ward not getting sulfanilamide. He is getting better in spite of it. We were unable to culture specific bacteria in his stools and cultures of a regional lymph node remained sterile.

DR. J. R. YOUNG (Anderson): For several years I have been interested in this theme and I have had this hunch—that this clinical entity is primarily due to mesenteric lymph adenitis. In infants and young children having intussusception there is always present definite mesenteric lymph adenitis. I recently operated on an infant having intussusception two hours after the onset of his symptoms and in this early hour there was definite involvement of the lymph glands. In some way involvement of the lymph glands of the mesentery seems to disturb the sequency in the peristaltic impulse and intussusception occasionally results.

I have wondered if regional ileitis in the older patient is not the pathological expression of a disturbed peristaltic impulse derived from disease in the mesenteric lymph glands. In infancy this same condition seems to result in intussusception where as in older patients regional ileitis is the result. The marked thickening of the intestinal tube may be due to a considerable extent, to the muscular hypertrophy induced by over exertion of the musculature resulting from disturbed peristaltic impulse. I have no clinical proof of this hypothesis. Several times we have removed large mesenteric lymph nodes during the course of an operation for the relief of intussusception or acute regional ileitis. A study of these glands has been fruitless, no organism has been recovered and there is present only a picture of acute inflammation.

I offer this only as an hypothesis.

DR. E. C. HOOD (Florence): I would like to begin by saying that I enjoyed Dr. Burnside's paper, and continue by saying that I am not a surgeon. Hence: I would not attempt to discuss Dr. Burnside's paper. There is one thing I would like to say to you gentlemen: the balance of us see some of these things also. A few years ago, a young lady came into our sanatorium. She had been treated for various illnesses. There was some vague female disorder and other things for which she had been treated. She had tuberculosis and we treated her for it. We did a temporary phrenic on one side and gave her pneumothorax on the other. When she began having vague abdominal symptoms, nobody apparently understood them and one surgeon and internal medicine man after another saw her. We were unable to get anything done about it until an exploratory operation was done. Then we found that the terminal ileum, the caecum and part of the transverse colon were badly thickened and the whole mass was enormous. It was resected and the girl improved for some weeks. Her tuberculosis became reactivated and she died of the tuberculosis.

DR. BURNSIDE: I appreciate the discussion very much. In regard to Dr. Kredel's remarks about removal of appendices in terminal ilitis, as I mentioned in my talk, it is only from literature and from the location of the disease that I feel certainly that the removal of appendices is contraindicated because it hasn't been definitely proved that the disease does not stop at the ileocaecal valve but it does involve the head of the caecum, so to remove the appendix, the head of the caecum is involved with the edematous tissue and the wall would not heal and in all the experience I have had they do get fecal fistulae.

Dr. Hood mentioned a patient with pulmonary tuberculosis. Intestinal tuberculosis and regional enteritis are very closely allied but there have been no cases of regional enteritis that could be proven tubercular; whereas with tuberculosis, enteritis can be proven by sections from the glands and thyroid.

THE JOURNAL
OF THE
South Carolina Medical Association

EDITOR-IN-CHIEF
Edgar A. Hines, M. D., F. A. C. P. ..... Seneca, S. C.

ASSISTANT EDITOR
J. I. Waring, M. D. ..... Charleston, S. C.

ASSOCIATE EDITORS

Internal Medicine
J. H. Cannon, M. D., F. A. C. P. ..... Charleston, S. C.

Pediatrics
R. M. Pollitzer, M. D. ..... Greenville, S. C.

Obstetrics and Gynecology
J. D. Guess, M. D. ..... Greenville, S. C.

Urology
The S. C. Urological Society

Roentgenology
R. B. Taft, M. D. ..... Charleston, S. C.

Pathology and Bacteriology
H. H. Plowden, M. D. ..... Columbia, S. C.

Surgery
Wm. H. Prioleau, M. D., F. A. C. S. ..... Charleston, S. C.

Eye, Ear, Nose and Throat
J. F. Townsend, M. D., F. A. C. S. ..... Charleston, S. C.

Dermatology and Syphilology
J. Richard Allison, M. D. ..... Columbia, S. C.

Gastro-Enterology and Proctology
W. T. Brockman, M. D. ..... Greenville, S. C.

Nervous and Mental Diseases
E. L. Horger M. D. ..... State Hospital, Columbia, S. C.

Public Health
B. F. Wyman, M. D. ..... Columbia, S. C.

Orthopedic Surgery
Austin T. Moore, M. D. ..... Columbia, S. C.

Please send in promptly notice of change of address, giving both old and new; always state whether the change is temporary or permanent.

OFFICE OF PUBLICATION

Medical Building ..... Seneca, S. C.
Subscription Price ..... $3.00 Per Year

SEPTEMBER 1940

DEATH OF DR. WILLIAM A. PUSEY

The members of the South Carolina Medical Association have learned with deep distress of the death of Dr. Pusey, past President of the American Medical Association, and one of the famous dermatologists of the world. Dr. Pusey spent the greater part of his professional life in Chicago. He was born in Kentucky, the son of a country doctor but he maintained a profound regard for the deep South. He was particularly fond of South Carolina and the coastal region of the South Atlantic States. He had an intimate knowledge of the history of this State and often visited the Charleston sector. He was the guest of the State Medical Association at the Orangeburg meeting some years ago where he made many friends and he was delighted to keep through the years close touch with them by correspondence and otherwise. It was only a few months ago at the New York meeting of the American Medical Association that he met a group of these friends and for several hours discoursed about the glories of the old South and the marvelous development of the coastal region now going on. Dr. Pusey wrote much on the history of medicine and felt confident that a good doctor in any community would continue to occupy a high position in the social structure regardless of the changes going on around him. He had a keen insight into the implications of socialized medicine and had done much to enlighten the profession in this regard. Dr. Pusey was a friendly man and at any great assembly of the medical profession was always surrounded by a loyal and respectful group of his admirers. Few did so much for organized medicine as he.

HAVE YOU RETURNED YOUR QUESTIONNAIRE TO THE A. M. A.?

The latest reports indicate that up to the early part of August only about half of the doctors in South Carolina had returned their questionnaires. Just why this is so remains to be seen but it is hoped that with the vacation over and the ready for business slogan of the fall apparent this matter will be attended to promptly. A few doctors report that they did not receive the questionnaires and a few say they misplaced them. The South Carolina Medical Association Headquarters office will be glad to supply questionnaires to all who need them or they may be secured direct from the American Medical Association. This document may look a little formidable on first sight but actually it can be filled out in about

five minutes. Organized medicine has undertaken to provide complete information to the government on the availability of the medical profession of this country for medical defense and the plan adopted seems to be the most feasible one hitherto tried. The plan offers a satisfactory medical service for the military units and also for the civil population in the event of a national emergency.

In this connection it will be of interest to note that at the time of going to press the State Committee on Medical Preparedness has been appointed, the members of the Council having been requested to act in this capacity and committees have been appointed in practically every county in the State. These various committees cannot function to the fullest extent until the questionnaires have been signed and sent in to the American Medical Association.

CONTENTS

ORIGINAL ARTICLES:

Observations on the Conduct of Labor. By J. Decherd Guess, M. D., Greenville, S. C. ---- 241

The Orthopaedic Problem in the South. By Austin T. Moore, M. D., Columbia, S. C. ---- 244

Regional Enteritis. By A. F. Burnside, M. D., Columbia, S. C. ---- 249

EDITORIALS:

Death of Dr. William A. Pusey ---- 253

Have You Returned Your Questionnaire to the A. M. A.? ---- 253

Surgery ---- 255

Woman's Auxiliary ---- 256

Pathological Conference, Medical College of the State of South Carolina ---- 258

South Caroliniana ---- 260

Minutes ---- 261

Dedication of Portrait of Dr. Edward Frost Parker ---- 266

SURGERY

WM. H. PRIOLEAU, M.D., F.A.C.S., CHARLESTON, S. C.

THE LATE RESULTS OF THE INJECTION TREATMENT OF HERNIA

The introduction of a therapeutic procedure which gives promise of circumventing an operation is generally met by such enthusiasm that some time must elapse before it can be properly evaluated. Such is the case with the injection treatment of hernia. The first reports were so encouraging that not to use it made one appear unprogressive and even to be operating unnecessarily. About 10 years have passed since this method of treatment came into vogue, and now there are appearing in the literature considerations based upon wide clinical experience and well controlled experimental work. Some of its early enthusiastic supporters now recognize it to have a very limited application. Worthy of review is an article by Leonard Dobson of San Francisco, from the Hernia Clinic of Stanford University Medical School (Surgery 7:836, June, '40).

In their experimental work dogs were used. They formed particularly suitable subjects in that they normally have a patent processus vaginalis which for this purpose may be likened to a small indirect hernial sac. By the injection of any of several commonly used sclerosing agents into the inguinal canal an abundance of scar tissue could be produced. At first this effectively closed the canal, however after a passage of some months it was found that the scar tissue disappeared with the exception of a few fibrous bands which in some cases constricted the sac by pressure. In general the lining of the sac remained smooth though in a few instances its walls were adherent in places. The injections caused considerable destruction of muscle, the loss of which might weaken the abdominal wall following the absorption and contraction of the fibrous tissue.

The clinical results were what would be expected judging from the experimental findings. Patients were treated by injection only after they had refused operation. At first all types of hernia were treated by the injection method but after 1½ years it was found that the recurrence rate was so high for direct and postoperative recurrent hernias that thereafter only indirect inguinal hernias were accepted. The technic of treatment will not be considered here except to say that it was thorough and according to the generally advocated method.

In 68 cases of indirect inguinal hernia treated there was a recurrence of 37%. In 21 direct hernias there was a recurrence of 68% and in 12 postoperative recurrent hernias there was a recurrence of 100%. In the series it is worthy of note that there were no serious complications, though there were a number of mild ones such as transient swelling of the testis, the cord and the abdominal wall, and intraperitoneal injection.

It is the opinion of the author that the sac is rarely obliterated, the whole basis of cure in the injection treatment of hernia is the fibrous tissue which persists between the fascial planes, muscle layers, and spermatic cord. These adhesions hold the hernia sac compressed and prevent omentum and bowel from entering the neck of the sac. It is concluded that the injection treatment of hernia should be used only in small indirect inguinal hernias in patients with otherwise good abdominal structures who will not or can not be operated upon.

WOMAN'S AUXILIARY

SOUTH CAROLINA MEDICAL ASSOCIATION

ADVISORY COUNCIL

Dr. E. A. Hines, Chairman — Seneca, S. C.
Dr. Robert Durham — Columbia, S. C.
Dr. Edith Eskrigge — Columbia, S. C.
Dr. Jesse O. Willson — Spartanburg, S. C.
Dr. Leon Banov — Charleston, S. C.

OFFICERS

President, Mrs. H. L. Timmons, 3017 Kirkwood Road, Columbia, S. C.
President Elect, Mrs. R. M. Pollitzer, 32 W. Hillcrest Drive, Greenville, S. C.
First Vice President, Mrs. L. H. McCalla, 219 McDaniel Ave., Greenville, S. C.
Second Vice President, Mrs. J. G. Hart — Laurens, S. C.
Recording Secretary, Mrs. David Adcock, Columbia, S. C.
Corresponding Secretary, Mrs. Ben Miller — Columbia, S. C.
Treasurer, Mrs. J. W. Kitchen — Liberty, S. C.
Parliamentarian, Mrs. J. W. Bell — Walhalla, S. C.
Publicity Director, Mrs. J. L. Sanders — Greenville, S. C.

STATE CHAIRMEN

Student Loan Fund, Mrs. L. O. Mauldin, Greenville, S. C., and Mrs. T. A. Pitts, Columbia, S. C.
Treasurer Student Loan Fund, Mrs. J. L. Bundy, Rock Hill, S. C.
Jane Todd Crawford Memorial Fund, Mrs. I. H. Grimball, Greenville, S. C.
Public Relations, Mrs. Emmett Madden — Columbia, S. C.
Hygeia, Mrs. A. F. Burnside — Columbia, S. C.
Historical, Mrs. J. E. Orr — Seneca, S. C.
Membership, Mrs. R. D. Hill — Pacolet, S. C.

COUNCILLORS

District No. 2, Mrs. E. C. Ridgell — Batesburg, S. C.
District No. 3, Mrs. J. R. Power — Abbeville, S. C.
District No. 4, Mrs. W. B. Furman — Easley, S. C.
District No. 5, Mrs. W. C. Whiteside — Rock Hill, S. C.
District No. 6, Mrs. W. E. Mills — Sumter, S. C.

PRESIDENT'S MESSAGE

In this, my first message through the Journal to the Woman's Auxiliary to the South Carolina Medical Association, I want to express sincere appreciation for the privileges extended to us by this splendid publication. To the members of the Auxiliary, I would acknowledge a profound sense of responsibility as well as gratitude for the confidence and cooperation accorded me as President.

The organization, as it stands today, merits the high regard and best efforts of every doctor's wife in the state of South Carolina.

Since you cannot inform others unless you yourself are informed, these vacation months since the convention held in Charleston, have been spent in study of local and national policies and programs, and in correspondence with national and state officers.

Our organization has a small membership, but in efficiency and spirit of cooperation, it merits the high esteem and commendation of national officers.

For the year 1940-41, we hope that every county auxiliary will adopt a program which will:

1st—Attract New Members. There are still far too many eligible women outside our ranks.

2nd—Increase attendance of each meeting.

3rd—Stimulate Interest in the Educational Work as suggested by the Medical Societies in county, state and national.

4th—Give serious thought to the social side of the organization by planning to bring members into close, friendly relationship.

5th—Continue the high efficiency of the Student Loan Fund by giving it our enthusiastic cooperation.

We would urge that each County Auxiliary compete for the three trophies which are awarded annually.

1. Pubilicity: Given by Mrs. T. R. W. Wilson of Greenville for the scrapbook containing the greatest amount of publicity contributed by that auxiliary and arranged in the neatest scrapbook.

2. Historical Award: Given by Mrs. Frank Strait of Rock Hill to the County Historian who writes the best account of unit activities for the year.

3. Health: First given by Mrs. C. C. Ariail of Greenville, continued by Mrs. W. B. Furman for the best health project or health education conducted on the membership basis. To be promoted by lectures, health plays or health projects.

If plans to compete are made early and kept before the membership all during the year, much good will be accomplished. Let's make this a real contest and may the best auxiliary win, whether it's membership be large or small.

We are expecting all officers to attend the Fall Board meeting to be held in Columbia; and to be prepared to give an outline of objectives for the year. We can then discuss these plans and be mutually helpful.

Remember always that we are an auxiliary

body and welcome any suggestions made by Councilors or Medical Societies.

Looking forward to a year of service and mutual helpfulness, I am

Very cordially yours,
Louise M. Timmons (Mrs. H. L.)

MESSAGE FROM STATE PUBLICITY CHAIRMAN

As State Publicity Chairman of the Woman's Auxiliary to the S. C. Medical Association I am making an appeal to each Auxiliary President to inform her publicity secretary that in order to take advantage of the courtesy extended the Auxiliaries by the South Carolina Medical Association Journal that all reports, publicity and activities of each Auxiliary will have to be mailed to your State Publicity Chairman before the 20th of the month previous to one of publication.

Therefore with an earnest desire to serve in this capacity to the best of my ability may I urge you to be prompt with your report.

Thanks
Sincerely,
Miriam Sanders
Mrs. J. L. Sanders, State Publicity Chairman, 103 Crescent Ave., Greenville, S. C.

MRS. J. C. PEPPER HOSTESS TO PICKENS MEDICAL AUXILIARY

The Pickens County Medical Auxiliary held their July meeting at the home of Mrs. J. C. Pepper, Easley, S. C. The meeting was called to order by the President, Mrs. P. E. Swords, with ten members being present.

Mrs. J. L. Valley led the devotional period followed by the Lord's Prayer being repeated in unison. After the business transactions, "Health Grams" were distributed to each member and they were asked to give the highlights contained therein.

A social half hour was enjoyed and the hostess served her guests delicious punch with sandwiches and cookies.

Ruth deS. Furman

OCONEE COUNTY MEDICAL AUXILIARY

The June meeting of the Oconee County Medical Auxiliary was held on Monday afternoon, June 10, at the home of Mrs. J. E. Orr, Seneca. The 100th Psalm was repeated in unison as the devotional and roll call was answered by those present with an outstanding project of the Oconee County Auxiliary carried out since it was organized.

The spacious reception rooms were beautiful for the occasion with quantities of colorful garden flowers. Mrs. Orr, Vice President, presided over the meeting in the absence of Mrs. S. H. Ross, the President.

The program included a splendid talk by Miss Sue Gignilliat of Seneca on her trip to Guatemala and a paper on "The History of the Oconee County Medical Auxiliary," written by Miss Leola Hines, a member of the Auxiliary, and read by Mrs. J. N. Webb.

After the business session and program the hostess served a delicious salad course.

REPRINTS

Of your article in The Journal may often be called for. Type on the Original Articles is held thirty days after publication, affording a considerable saving in the cost of reprints.

Don't fail to order reprints!

PROVENCE-JARRARD COMPANY, Inc.
Greenville, S. C.

Pathological Conference, Medical College of the State of South Carolina

KENNETH M. LYNCH, M. D., PROFESSOR OF PATHOLOGY

Case of Dr. F. E. Kredel

ABSTRACT NO. 412 (61672)

Student Maguire (Presenting).

Admitted Nov. 6; died Nov. 19.

History: The patient, a white man, age 28 years, a truck driver was brought to the hospital by friends. The patient was unable to give a history. According to one friend, the patient had developed "eye trouble" about 3 days prior to admission. At this time he had been drinking rather heavily and had told conflicting stories of having been hit on the head and of having slipped and struck his head. No reliable detail could be learned concerning the duration of his trouble or the events that had transpired immediately prior to admission. However, his estranged wife stated that he had complained of headaches for about one year. She further stated that she had noted personality changes. Her husband was "mentally unstable" and "quick tempered." He had been quite a heavy drinker. Details of the past history and review of systems were not obtainable.

Physical: T—98.2 P—64 R—24.

The patient was a well developed and well nourished young white man tossing about in bed. Though apparently cooperative and able to talk there was definite clouding of consciousness and incoherence in response to questions. There were no lesions of the skin or mucous membranes. No external evidence of head injury. The pupils were dilated (atropine). No nystagmus or other abnormal extraocular movements. The tongue protruded in the midline. The nose and throat were not remarkable. No lymphadenopathy noted. The neck was stiff and attempt at manual flexion produced pain. The chest was clear to P and A; the mediastinum was not widened to percussion. Heart was normal in size, rate slow, rhythm regular and sounds of good quality. B. P. 110/75. Radial arteries were readily compressible. The abdomen showed a well healed McBurney scar. There was no tenderness to pressure and no organs or masses were palpable. Genitalia and extremities were not remarkable. The cranial nerves appeared intact. The deep reflexes were uniformly hyperactive. Sensory and motor functions were apparently intact. No spasticity or flaccidity; no pathological reflexes were demonstrable.

Laboratory: 11/7 Urinalysis. No abnormal findings.

11/7 Blood. Hb. 93%. RBC 5,450,000. WBC. 22,400. Polys 86%. Lymph 11%. Mono 3%.

Kolmer and Kline. (Blood and Spinal Fluid). Neg.

Spinal Fluid. 11/8 Microscopic blood—xanthochromia. Cells 195, Lymphs 53% Polys 47%.

Course: Lumbar puncture showed initial pressure of 480 mm. Pressure on left jugular produced rapid rise to 550 mm. with rapid fall—pressure on right produced rise to 530 with rapid fall to 450. Condition remained constant and no localizing signs were found until 11/12 when the patient became comatose, and developed flaccid paralysis of entire right side. Papilledema, noted two days previously, became more pronounced. Subsequent lumbar punctures showed essentially same findings as above. Death occurred on 11/19.

I can only say that upon admission, this patient gave the appearance of a typical drunkard. He quite definitely had delusions of persecution. The only additional history obtained from his family was that of his mother-in-law who stated that he was a drunkard and that once had an attack of hives. One friend gave out the story that the patient had been on a drinking party. Another friend stated that the patient had fallen in the bath tub, and struck his head a few days prior to admission. The same friend stated that the patient had been suffering from headache and had consulted and been treated by a chiropracter.

From the standpoint of the physical examination, the patient was very restless upon admission, tossed about in bed and had the general appearance of one reviving from the effects of overindulgence in alcohol. There were no abnormal eye signs at that time, the neck was rigid and Kernig's sign was 4 plus. The spinal fluid on admission was xanthochromic and a few crenated red cells were found. The highest recorded blood pressure was 160/100. The delusions continued, the patient believed himself to be in France fighting Germans and at other times in a restaurant sustaining bodily injury in personal combat.

Dr. Kredel (Conducting): Mr. Allen, from the data at hand, will you please give us your diagnosis in this case and the reasons for your impression.

Student Allen: Increased intracranial pressure was indicated by headache, eye signs and choked discs. The blood in the spinal fluid may have been on the basis of a ruptured vessel, possibly related to trauma, arteriosclerosis or hemorrhage into a tumor. Chronic subdural hemorrhage may simulate brain tumor and produce the signs of meningeal irritation that were evidently present in this case. The afebrile course is against the latter being on an

infectious basis. Congenital cerebral aneurysm is also a good possibility in this age group. The element of trauma was not substantiated by demonstrable evidence of head injury. I believe the entire picture was one indicative of some sort of vascular condition.

Dr. Kredel (Conducting): What do you mean by vascular condition?

Student Allen: Disease of the vessel proper, resulting in hemorrhage into the subarachnoid space.

Dr. Kredel (Conducting): Mr. Cone, what is your diagnosis?

Student Cone: I believe that the picture points to left sided vessel rupture with slow hemorrhage gradually involving the internal capsule, possibly by virture of the surrounding encephalomalacia. This was probably followed by terminal massive hemorrhage just prior to death.

Dr. Kredel (Conducting): How do you feel about the possibility of this all being due to trauma?

Student Cone: I suppose it is possible but it is difficult to feel certain that trauma played a part in this picture, particularly since the history was so unreliable

Dr. Kredel (Conducting): Do you believe that a blow to the head received 10 days before this patient was first seen could have caused sudden hemorrhage at a later date?

Student Cone: No I don't believe that is probable. If the hemorrhage was related to trauma it must have been a very slow cumulative affair rather than one of delayed occurrence. I believe that congenital cerebral aneurysm is a verg good possibility in this case. They tend to give this sort of clinical picture and commonly occur in this age group.

Dr. Kredel (Conducting): If you were to assume that the patient's mental changes were not due to alcoholism, do you think that their character would help in the localization of the brain lesion?

Student Cone: Yes, I believe that frontal lobe involvement was present and that a congenital cerebral aneurysm gradually enlarging over a prolonged period of time might well have produced this picture.

Dr. Kredel (Conducting): Mr. Shuler, what do you think of the possibility of a brain tumor in this case?

Student Shuler: A tumor could explain the personality changes, headache, chocked disc, hemorrhage and paralysis.

Dr. Kredel (Conducting): Do you think that this could have been apoplexy?

Student Shuler: No I would not suspect apoplexy because of the patient's age and absence of all evidence of hypertensive state and demonstrable arteriosclerosis. Then too, the whole picture, with paralysis ensuing later, was too insiduous in its development.

Dr. Kredel (Conducting): What do you think of the eye trouble as described in the history and the stiffness of the neck?

Student Shuler: The increased intracranial pressure, probably due to clot at the base of the brain, could account for the choked discs and the subjective eye symptoms. The stiffness of the neck can be attributed to meningeal irritation caused by the blood clot.

Dr. Johnson: What were the X-ray findings?

Student Maguire (Reading from Chart): "There is no X-ray evidence of fracture or other pathological changes of the bones of the skull. The sella is rather shallow. The pineal is in the midline."

Dr. Chamberlain (Faculty Discussion): The history in this case doesn't tell us much of what happened during the last year of this patient's life. The wife's statement doesn't mean much, typical for any case in which divorce is pending. The labor history in such a case would have been helpful. That is, had this man actually been driving a truck, or been otherwise employed immediately prior to his terminal illness. However, there is enough in the history to indicate changes in the brain which might have had a background in tumor or pachymeningitis hemorrhagica interna, as seen in chronic alcoholics, resulting in formation of plaque-like tumefaction external to the brain proper. This patient, no doubt, suffered intracranial hemorrhage which became massive in proportions terminally.

Dr. Wilson: At what site do you believe the hemorrhage occurred?

Dr. Chamberlain: Left side, extending to involve the left motor area. I recall having seen encephalitis in the twenties that gave a frankly bloody spinal fluid and don't see how it could be positively ruled out, clinically, in this case. However, subarachnoid hemorrhage, possibly due to cerebral aneurysm, seems a more likely prospect.

Dr. Cannon: I believe the duration of this case is against hemorrhagic encephalitis. It tends to run a more fulminating course and the patient is more acutely ill in the early stages of the disease than was apparently true in this instance.

Dr. Kredel (Conducting): This was a very puzzling case, clinically. When I first saw this man 4 days after admission, he had choked discs. This was indicative that the underlying intracranial condition had been in progress over a period of time. There was no doubt about hemorrhage and we felt that something positive should be done. Accordingly, a subtemporal exploration was made but no sign of tumor, or other explanation for the bleeding, was found. There was no evidence of hemorrhage seen at operation though the brain was edematous.

On the basis of the patient's age, positive evidence of hemorrhage at the base of the brain and in the absence of any demonstrable arteriosclerosis or syphilis. I made the diagnosis of leaking aneurysm of the Circle of Willis.

Dr. Lynch (Demonstrating Brain Specimen): This is a very pretty demonstration of the condition that Dr. Kredel has mentioned. There is an aneurysm

at the junction of the anterior and middle cerebral arteries on the left side, really within the Circle of Willis. This runs true to form for this sort of condition. The aneurysm tends to occur at the bifurcation of the vessels in the arterial circle at the base of the brain. The formation, is, supposedly, due to congenital weakness in the musculo-elastic components of the vessel wall at the site of bifurcation. Just when these saccular dilatations develop at the points of weakness is hard to say. The resultant hemorrhage is often small in the beginning, then there is commonly further bleeding with fatal issue. The increased intracranial pressure in this case was from the hemorrhage which resulted in clot formation about the aneurysmal sac. There is, as you can see, considerable softening of the brain substance of the left frontal lobe about the aneurysmal sac, with clot formation, extending in toward the lateral ventricle with actual rupture into the latter.

I would have thought of brain tumor in this case but would have expected severe headache and vomiting extending over a longer period of time.

Dr. Chamberlain: Was there any evidence of old hemorrhage?

Dr. Lynch: No, the hemorrhage was all apparently of recent vintage. In addition to the leaking aneurysm with clot formation and softening of the brain substance, there was recent thrombus formation in both the Sylvian vein and middle cerebral artery on the left side. There was terminal bronchopneumonia.

SOUTH CAROLINIANA

J. I. WARING, M.D., CHARLESTON, S. C.

CONGENITAL FLAT-FOOT. A NEW SURGICAL APPROACH, by J. W. WHITE. GREENVILLE. J. BONE & JOINT SURG. 22:547, JULY, 1940.

Dr. White gives the treatment of the severe form of congenital flat-foot. It consists essentially of removing a wedge of bone from the neck of the astragalus; thereby shortening the inner and lengthening the outer border of the foot.

THE PRACTICAL APPLICATION OF HEPATIC FUNCTION DETERMINATIONS; THE PROTHROMBIN LEVEL AND VITAMIN K THERAPY, by J. M. FEDER. ANDERSON. SOUTH. MED. & SURG. 102:347, JULY, 1940.

The author describes the technique of a simple test of hepatic function, and discusses the prothrombin level in relation to hemorrhage.

PREGNANCY SPACING IN MATERNAL WELFARE, by R. E. SEIBELS. COLUMBIA. SOUTH. MED. & SURG. 102:230, MAY, 1940.

A resume of the work of the Committee on Maternal Welfare of the South Carolina Medical Association, work which has received national approval and commendation.

RETROPHARYNGEAL ABSCESS WITH REFERENCE TO ABNORMALLY LARGE PERCENTAGE OF ADULT CASES, by J. E. SMITH. ANN. OTOL., RHIN. & LARYNG. 49:490, JUNE, 1940.

Dr. Smith calls attention to the various conditions which confuse the diagnosis of retropharyngeal abscess, and summarizes a number of cases. The treatment and its dangers are discussed.

SOME NEW THINGS IN OTITIS MEDIA AND MASTOIDITIS, by J. F. TOWNSEND. CHARLESTON. SOUTH. MED. & SURG. 102:291, JUNE, 1940.

A discussion of older and newer methods in the management of those diseases.

STUDENT HEALTH WORK, by C. N. WYATT. GREENVILLE. SOUTH MED. & SURG. 102:357, JULY, 1940.

Dr. Wyatt outlines the problems of student health work and the broad duties of the physician in charge, especially as regards health education of the student body as well as the management of disease.

SUPRAPUBIC PROSTATECTOMY WITH THE USE OF AN ORIGINAL COMBINATION HEMOSTATIC DRAINAGE TUBE, by L. P. THACKSTON. ORANGEBURG. SOUTH. SURG. 9:403, JUNE, 1940.

The author gives a complete and well illustrated account of the technique for the use of the special tube described.

THE WELL-LEG SPLINT IN FRACTURES OF THE FEMUR, by W. C. HUNSUCKER AND D. JENNINGS. BENNETTSVILLE. SOUTH. MED. & SURG. 102:239, MAY, 1940.

The authors find that this method not only gives best results but also makes life during the time of treatment much better for the patient.

MINUTES

MINUTES HOUSE OF DELEGATES CONTINUED

The House of Delegates reconvened at 8:50 Tuesday evening, April 30, 1940 in the Ball Room of the Francis Marion Hotel with the President, Dr. Douglas Jennings, presiding.

Dr. Roger Doughty was asked to report for the Committee on Medical Economics. (Absent)

Dr. J. I. Waring reported for the Committee on Historical Medicine.

PRESIDENT JENNINGS: What shall we do with the report of the Committee on Historical Medicine?

SECRETARY HINES: I'd like to say that it has been my privilege to go around to the Medical College and to go over the records collected by this Committee and to see the splendid work that has been done there. As your Secretary I promised to bring the matter to the attention of the Council tomorrow. It depends on the Council's wishes whether or not they will see fit to appropriate funds but at any rate I am promising the Chairman to bring it to the attention of the Council, which is really the financial body of the House of Delegates. It is a very excellent piece of work so far and I hope when you go to the Medical College you will visit their collection there.

Upon motion of Dr. Des Portes, duly seconded, vote taken and carried, report accepted.

PRESIDENT JENNINGS: We will have the report of the Committee on the Medical College of the State of South Carolina by Dr. L. M. Stokes.

DR. STOKES: Mr. President and Gentlemen of the House of Delegates: This report is largely a statement and an appeal. The physicians of South Carolina have for many years realized that our Medical College was of first importance in medical care for the people of South Carolina. For a great many years the alumni have raised funds which they called expansion funds to erect at the Medical College a clinical building and had it not been for the bank failures and depression the Medical College would have been dedicated now from the gifts of the people.

In thinking of medical care there is nothing more inspiring to me as a medical man than the fact that the physicians of South Carolina were willing to go down in their pockets and give their hard earned money to educate physicians to come out and practice with them. I think that is one of the best commentaries on the spirit of the men engaged in the practice of medicine today.

When this alumni fund fell through, the State Association sponsored the Medical College as of first importance in medical care. Your sponsorship of that institution and your work in the Legislature in 1938 has brought us in sight of the dedication of this new building.

The dedication of the addition to the Medical College will take place at 4:30 o'clock Wednesday. Gentlemen, I know that is just as much a pleasure and joy to you as it is for your chairman and I would like to say that now that we are in sight of this building, we have learned how to succeed in working in the interest of the people of South Carolina through medical care. We know what the hardships are and what the objections are and the disinclination of the Legislature to supply this fund. They told us they had already adopted a resolution that no institution was to receive a new building that year. That was the information the ways and means committee got. We were not satisfied with that. We called a meeting of the House of Delegates in Columbia and it was the result of your response and your work that we received a bond issue of $150,000.00 for this building. Now, although that every year other educational institutions in the State of South Carolian received $1,350.00.00 for additional buildings, the Medical College did not get a red cent. The State had owned the institution for 25 years and had contributed just $55,000.00 for building purposes. We have learned how and today, or tomorrow when we dedicate that building, it is going to be necessary for that building to have the necessary funds on which to operate. Now that we do not any longer have to ask the Legislature for building funds, it would be the pleasure of your chairman to see every member of the House of Delegates and every physician in South Carolina pledge ourselves to secure adequate annual appropriation for our Medical College.

The Dean made the statement to the ways and means committee in Columbia some time since that the average support to give proper training to the number of students in this school would be $225,000.00 per year. Now, Gentlemen, it is a clear cut, common sense business proposition. Without the funds with which to employ teachers, we can not instruct our students and we cannot expect talent to be employed in this institution unless we provide the funds with which to employ that talent. It follows as a logical result that the talent we have will leave as soon as they have opportunity unless we provide the funds, so your chairman makes the appeal that we dedicate ourselves to the high resolve of seeing that this school gets an adequate annual appropriation and make this new building as effective as possible and bring the very best medical care for our people in South Carolina.

I thank you. (Applause).

DR. ROBERT WILSON: May I take this opportunity of saying to all the members of the Association that the exercises at the College are late tomorrow afternoon but the College is available for inspection and students and others will take any one through who wishes to go through. We would be glad to have you all come at whatever time you wish to visit the institution and see what we have done with the alumni money. (Applause).

Upon motion of Dr. Des Portes, duly seconded, the vote was taken and Dr. Stokes' report accepted.

PRESIDENT JENNINGS: We will now have the report of the Cancer Commission, Dr. K. M. Lynch.

DR. K. M. LYNCH (Charleston): Mr. President and members of the House of Delegates: At the last meeting of this body in Spartanburg, I reported the program which we then proposed to develop toward bettering the cancer situation in this State, and our aims toward the enactment of a law directing the State Board of Health to set up a cancer control division. Since that meeting a year ago that law has been enacted, not only allowing the Board of Health to organize this division but directing it to do so and giving it the opportunity for the development of the program in a way in which it could be developed into something worth while. In other words, by giving it the opportunity to seek funds through which such work could not be done without money. The law which was passed did not carry any appropriation and we were then, therefore, up against the impossible situation of being able to do anything material without funds. However, through the State Board of Health, that organization is now completed and we consider ourselves very fortunate in having at the head of that division Dr. C. L. Guyton who has taken hold remarkably well and has executed and matured the sort of program which we had in mind.

The aid comes from the government for the treatment of indigent cancer patients. I will not take the time here to go over that whole program but it has been worked out in as careful detail as it is possible to do without more experience than has been had up to the present time, using as a guide not only what we wanted to do but what the experience has been in other states where such programs are already instituted. I think if you will read, as you must have received it, the regulations and course of procedure through which this work is to go you will realize that Dr. Guyton has put considerable time and effort on it and in so far as it is possible to foresee we have safe-guarded the procedure to include only help to actually indigent patients. This is safe-guarded by a number of factors. In the first place, the individual, the patient, has to be a patient of a doctor and that doctor has himself to certify that that patient is unable to pay. He certifies that to the County Health Department and further to the County Welfare Board or such agency as may exist for that care in each County and then to the Division of Cancer Control and the patient goes to a cancer clinic where that is still further investigated so that would seem so far as possible to safe-guard the use of this money for those actually indigent and do not merely claim to be indigent and if there is a loophole in it it is largely in the doctor himself as the patient has to come from a doctor in the first place and if that patient is able to pay, the doctor himself says he is.

In the course of procedure of getting a cancer patient to an approved cancer clinic, of course there is necessarily some time to be used before that patient can actually be brought under treatment. That is necessary. A patient can't come directly to the cancer clinic. He has to go through a certain course of procedure in order to assure us that that money will be spent properly and for the person that it is designed for so it may apparently take a little more time for the individual but after all cancer is not an emergency disease so that the loss of a few days in the ordinary run of the mill cases means very little. I will not go over that procedure but it will be easy enough to find the division of cancer control through the Board of Health.

Cancer clinics have been organized and approved by the Cancer Commission of the State Board of Health to operate wherever there are sufficient facilities for those cancer clinics to be held in Columbia, Spartanburg, Sumter, Florence, Charleston, and probably Rock Hill as soon as they have completed their organization, so that there will be a cancer clinic within easy automobile distance to any of the prospective people who are to use it.

It is natural, of course, that the individuals concerned in the prospective treatment and diagnosis should go to the nearest clinic but that is not even required. Wherever the doctor prefers his patient to be referred, that will be carried out. If there is no request as to which clinic, then he will be sent to the nearest.

Of course the money available is quite limited and it will not last long. At the present it is first come, first served and not a pro rata in various regions of the state. It is the design that the people who are now in a state of indigency obtain proper diagnosis and treatment. It is the design to get such people early enough to do something about it.

We realize as well as you do that this is entering into the field of curative medicine under the auspices of the State Board of Health but no agency of it is really going to do the work. The work is going to be done by you all. The cost of the work is only going to include the actual expense on the part of the hospital and the cost of the clinic. No physician is to receive any remuneration whatsoever. Fees which are set to cover the costs are contemplated only for compensation for the hospitals for the expense to which they are put in handling patients. Those hospitals in the centers which I have mentioned have agreed to take care of them so far as their capacity will allow at a set cost so far as the

money will go. When the money gives out, of course, we will stop the program.

The program is set to begin tomorrow. Everybody has been notified so they will be on an even start and have an equal opportunity. Everybody concerned with the program will be ready to begin tomorrow to go as long as this fund lasts. We hope it will not stop at the end of this particular proposition.

There is one matter in connection with the law that I think it necessary to clarify here. In the writing of this Act, as so often happens in the vicissitudes of some proposed act, some words are not exactly as they were designed. First I want to distinguish between the cancer commission which is an advisory commission to the State Board of Health, and the cancer educational program which is controlled by the cancer committee of this Association, long in existence and whose objective has always been largely educational. The interests of the two do not conflict. The cancer commission is a body of physicians selected, one from each District in the State to advise the State Board of Health just like a similar committee in the crippled children's work. That commission was set up at the request of the State Board of Health by the then President of the Association, Dr. Des Portes; I believe he appointed those on the commission. That has been in existence right along from the beginning of the program. I want you to be sure to distinguish between the cancer committee and the State Cancer Commission. Now the law reads, "that the State Board of Health shall consult with physicians designated by the President of the State Medical Association." It was intended that that refer to the cancer commission in order that there might not be misunderstanding there and that it may be clear. If I may presume to do so, I am going to offer a motion, that the cancer commission as it is now set up, be designated as the body of physicians to be consulted by the State Board of Health in accordance with the cancer control law and that vacancies on the commission shall be filled by the President of the Association. I offer that as a motion, Mr. President. (Applause).

PRESIDENT JENNINGS: You have heard the motion embodied in the report of the cancer commission. Is there a second to the motion?

Motion, seconded, vote taken and carried.

PRESIDENT JENNINGS: Is there any discussion of the report of the cancer commission? There being no objection to the acceptance of the report, it will be accepted as given by Dr. Lynch.

We will now have the report of the Delegates to the American Medical Association, Dr. J. H. Cannon and Dr. E. A. Hines.

SILVER PICRATE

Wyeth

is indicated in the treatment of

★ Acute Anterior Urethritis (due to Neisseria gonorrheae)

★ Trichomonas Vaginalis Vaginitis

★ Vaginal Moniliasis

★ Bartholinitis and Skeneitis (due to Trichomonas Vaginalis)

Silver Picrate is a definite crystalline compound of silver and picric acid. Available in the form of crystals and soluble trituration for the preparation of solutions; suppositories; water-soluble jelly; and powder for insufflation.

Complete information mailed on request

★ JOHN WYETH & BROTHER, INCORPORATED ★

PHILADELPHIA, PA.

DR. HINES: Mr. President, Dr. Cannon and I had a conference and he was to make the report but he has been called out and perhaps he will not get back and I shall make some brief remarks about the report.

Of course the A. M. A. meeting at St. Louis has long since been past and most of the information has been in your hands for many months. Quite a number of you subscribe to the Journal of the American Medical Association and our own publication carried the report fairly well of what happened at St. Louis.

The eyes of the world are on us particularly with reference to our action on the Wagner Health Bill. The South Carolina Medical Association House of Delegates previously had turned it down and that is exactly what was done by the House of Delegates of the American Medical Association at St. Louis with certain stipulations and recommendations that you are familiar with.

I think, a telegram from the Secretary of the American Medical Association on April 24th to the Secretary of the South Carolina Medical Association, on the progress of the Bill will be of interest.

Dr. Hines read the telegram.

Following this, Dr. Hines read communication from Washington, dated April 25, 1940, on the Taft Amendment to the Bill.

I thought you'd be interested in this latest information on the subject of the Wagner Health Bill.

Finally, Mr. President, just a word in regard to the scientific aspect of the American Medical Association. The scientific exhibits are now correlated with the section programs and they have been able to interest America's most distinguished physicians to go to these exhibits and demonstrate them to the members of the Association. It is one of the many advances of the American Medical Association. We, as your delegates, would like to urge the members of this Association to go to New York and take advantage of these newer developments.

Your senior delegate was appointed on the committee on Constitution and By-Laws which we look upon as an honor for only those who have had long experience in organization work are so honored.

I thank you. (Applause).

There being no objection to the acceptance of the report, it was accepted as given by Dr. Hines.

(Continued next month)

WANTED—In good condition, used eye, ear, nose and throat instruments, including optical trial case, trial frame, treatment chair, and operating instruments. Inquiries may be sent to Journal S. C. Medical Association, Seneca, S. C.

BLACKMAN SANATORIUM

A general medical, hydrotherapeutic and electrotherapeutic institution

ESTABLISHED OVER 30 YEARS

LIKE NEW THROUGHOUT

Clinical and X-ray Laboratory Service
25 Attractive Hotel Type Rooms
A Department for the Lambert Treatment for Alcohol
RATES MODERATE

418 CAPITOL AVENUE, S. E. **ATLANTA, GEORGIA**

Now EVERY Doctor Can Fit a Pessary

with the use of Bach Pessalator and Bach Soft Rubber Pessary

- No complicated system of sizes.
- Easy, accurate placement possible by use of Pessalator. Small in size—no metal spring in rim to frighten patient or to cause irritation.
- Pessalator made of special plastic, pessary of treated rubber, formed on precision molds.
- Price: Pessalator and Pessary $1.50 each. Samples (limited) 60% discount.

Instruction circular on request

Distributed by THE SANITUBE COMPANY Newport, R. I.

Are You FEEDING a Suitable FAT?

Yes, Some Fats Do Upset Them. Yet a proper fat is an essential part of every infant's diet. The addition of carbohydrate cannot compensate for the absence of a sufficient amount of a suitable fat.

SMA fat resembles human milk fat—has the same chemical and physical characteristics. And because SMA fat is like human milk fat the SMA carbohydrate is lactose, the only sugar present in human milk.

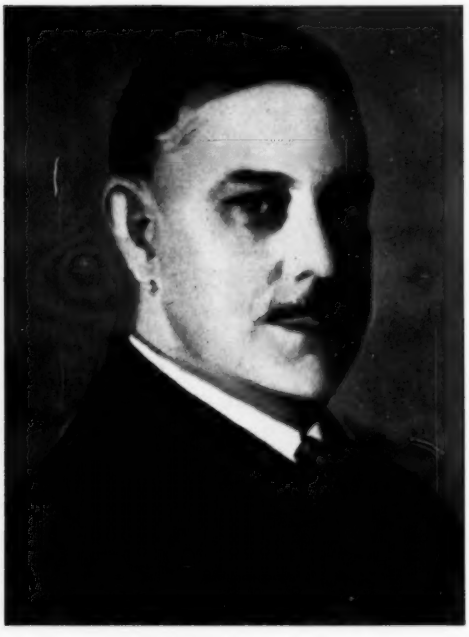
The percentages of fat, protein, carbohydrate and ash are the same as those in human milk and when prepared according to the physician's directions SMA is essentially similar to human milk.

Therefore, SMA may be fed to normal full-term infants without modification or change for the same reason that it is not necessary to modify human milk.

ACCEPTED AMERICAN MEDICAL ASSN.

Normal infants relish SMA—digest it easily and thrive on it.

S.M.A. CORPORATION • 8100 McCORMICK BOULEVARD • CHICAGO, ILL.



Dr. Edward Frost Parker

At the meeting of the Medical Society of South Carolina on June 25, 1940, Dr. R. S. Cathcart, Chairman of a special committee appointed by the Society, reported that the committee has discharged its duty in securing for the walls of the Society's Hall a portrait of its past president, Dr. Edward Frost Parker. This portrait, painted by Mr. M. John Lenhardt, was viewed by the Society and by the members of Dr. Parker's family who were present as guests at the meeting. The portrait was then presented to the Society by Dr. A. Johnston Buist, who delivered the following address:

Dr. Edward Frost Parker was born in Charleston in 1867. As a lad he attended school in Charleston, later being a cadet at the Citadel and after that completing his academic education at the University of Virginia. Deciding to follow in the footsteps of his father he entered the Medical College of the State of South Carolina in 1886, graduating from the institution in 1889. He then served on the house staff of the City Hospital and after that entered upon the general practice of medicine. During this period he served as Assistant Demonstrator of Anatomy at the Medical College and acted as Clinical Assistant to his father in diseases of the eye, ear, nose and throat.

In 1895 he decided to retire from general practice and to devote his entire time to the specialty that he followed for the remaining years of his professional life. To perfect himself he took postgraduate work in New York, Baltimore and the Royal Ophthalmic and Golden Square Hospitals in London, acting as Clinical Assistant in these institutions. After completing his studies he returned to Charleston, limiting his practice to diseases of the eye, ear, nose and throat, and continued his association with the Medical College. He was elected Professor of Physiology and Medical Jurisprudence, which position he occupied until 1911, at which time he was elected Professor of Diseases of the Eye, Ear, Nose and Throat. Upon the reorganization of the College as a state institution he was elected Professor of Ophthalmology and Otology and continued as executive head of the Department of Eye, Ear, Nose and Throat until 1935, when failing health compelled him to retire from active association with the college. At that time he was elected Professor Emeritus.

From 1906 to 1908 he acted as Dean of the Medical College.

From the time, shortly after his graduation, when he became a member of the Medical Society of South Carolina he took an active interest in the scientific, the business and the social sides of the society. Because of these activities and the confidence and admiration the profession had for Dr. Parker he had numerous honors bestowed upon him. He was past president of the Medical Society of South Carolina and a past president of the South Carolina Medical Association. He was a Fellow of the American College of Surgeons and in 1934 had the rare distinction of being elected to Honorary Fellowship in the American Laryngological, Rhinological and Otological Association. In 1935 he was appointed Oculist to the Southern Railroad, which position he held until his death.

During the First World War he was most faithful and active as a member of the Medical Advisory Board of the Third District of South Carolina, acting in the capacity of a specialist in diseases of the eye, ear, nose and throat.

From his earliest association with the Medical Society he was ever ready and anxious to give of his time and talent for its welfare. He occupied successively practically all of the elective offices in the gift of the Society. He served as librarian, secretary, a trustee of the Roper Hospital Fund, on the Library Committee, as a member of the Building Committee of the Roper Hospital, on the Board of Commissioners of the Roper Hospital, on the Committee on the Ross Bequest and for ten years on the Board of Finance.

But Dr. Parker's keen interest in the scientific and business side of organized medicine was not what mostly endeared him to the members of the profession and to the public at large. It was his wonderful personality, a personality that made everyone, high or low, rich or poor, refer to him as "Doctor Ned." He had a high respect for the ethics of medicine and of ethical conduct of his dealings with his fellow man. He was ever ready to assist with his time and talent the young man in his early struggles and uncertainties and to give his advice freely and without prejudice when it was sought. He had a high sense of humor and could look beneath the surface and see the bunk in many of the things that were called scientific, and often refused to follow the popular lead when he felt that such leadership was wrong. He was a wonderfully entertaining companion, an attribute that made him most welcome with all groups of people at all times. He was a wonderful host and nothing gave him greater pleasure than the entertaining of his friends. To know him was to love him and to be taken into the circle of his close friends was a privilege indeed.

Mr. President—your committee now presents the Society with the portrait of Dr. Edward Frost Parker, and we trust that you will instruct the librarian to hang it on the walls of the Society, which are now adorned by the portrait of his illustrious father.